

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-0877.M5**

**MDR Tracking Number: M5-04-3135-01**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5-19-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the electrical stimulation, myofascial release, mechanical traction, manipulation, office visits, therapeutic exercises, chiropractic manual treatment and therapeutic procedures group from 8-6-03 through 1-6-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 8-6-03 through 1-6-04 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27<sup>th</sup> day of August 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

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**NOTICE OF INDEPENDENT REVIEW DECISION**

August 23, 2004

**Re: IRO Case # M5-04-3135**, amended 8/25/04

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. Position Statement from requestor
4. Treatment and exam records from requestor
5. Radiology report lumbar spine 7/9/03
6. MRI report lumbar spine 7/25/03
7. Electrodiagnostic report 9/2/03
8. Medical report 9/4/03
9. Pain management reports 9/11/03, 9/12/03
10. Operative report 10/2/03

## 11. Medical report 10/6/03

### History

The patient injured her low back in \_\_\_\_ while cleaning behind a filler and conveyor belt. She received chiropractic treatment, and had passive and active physical therapy.

### Requested Service(s)

Electrical stim, myofascial release, mechanical traction, manipulation, office visits, therapeutic exercises, chiropractic manual treatment, therapeutic procedures group 8/6/03 – 1/6/04

### Decision

I agree with the carrier's decision to deny the requested services.

### Rationale

The patient received a fair trial of chiropractic treatment prior to the dates in dispute. Her VAS for pain was temporarily reduced from 10/10 to 5/10 during this period. By 10/2/03 her 5/10 VAS persisted, necessitating lumbar ESIs, which apparently failed to be beneficial. On 12/17/03, the patient's VAS had increased to 7/10, with restricted range of motion, and documented muscle spasms.

Based on the records provided for this review, it appears that the patient plateaued in a diminished condition on or before the dates in dispute. There was no documented change in her objective findings or subjective complaints during the disputed dates.

The prognosis for successful conservative treatment would be poor at best, given the MRI results and failed ESIs. The failure of conservative therapy does not establish a medical rationale for additional non-effective therapy. Treatment for the dates in dispute was inappropriate and unnecessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.